CalOptima Seeks Candidates to Participate on its Member Advisory Committee

The CalOptima Board of Directors welcomes input and recommendations from the community regarding issues concerning CalOptima programs. For this reason, the CalOptima Board encourages members and community advocates to become involved through an advisory group known as the Member Advisory Committee (MAC).

The **Member Advisory Committee** advises the CalOptima Board of Directors and staff. The CalOptima MAC is composed of 15 members representing the various constituencies that CalOptima serves. The charge of the committee is to:

- Provide advice and recommendations to the CalOptima Board on issues concerning CalOptima programs as directed by the CalOptima Board.
- Engage in study, research and analysis of issues assigned by the Board or generated by the committee.
- Serve as a liaison between interested parties and the Board.
- Assist the Board in obtaining public opinion on issues relating to CalOptima programs.
- Initiate recommendations on issues for study to the CalOptima Board for their approval and consideration.
- Facilitate community outreach for CalOptima and the Board.

Currently, CalOptima is seeking a candidate to participate on its Member Advisory Committee. **Service on the MAC is voluntary and with no salary.** The following two-year seat is available:

- **Consumer Representative**

The committee encourages interested individuals who receive Medi-Cal or an Authorized Family Member of a Medi-Cal recipient to apply. To apply or to nominate an individual for the Member Advisory Committee, please mail, fax or email the attached candidate application along with a **biography or résumé** to:

CalOptima
Attn: Cheryl Simmons
505 City Parkway West
Orange, CA 92868

Fax: **714-571-2479** or email: csimmons@caloptima.org

If you have any questions, please call **714-347-5785**.

MEMBER ADVISORY COMMITTEE

Member Application

Instructions: Please answer all questions. You may write or type your answers. If you have any questions regarding the application, call 1-714-347-5785.

Name: _____ Phone: _____
Address: _____ Cell Phone: _____
City, State, ZIP: _____ Fax Number: _____
Email: _____

This seat serves a two-year term ending June 30, 2020.
☐ **Consumer**

Current position (e.g., title, student, volunteer, retired, etc.):_____

_____

1a. What is your direct or indirect experience working with the CalOptima population you wish to represent on the MAC?

_____

_____

_____

1b. Include any relevant community experience.

_____

_____

_____

2a. What is your understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County?

_____

_____

_____

2b. Include relevant experience related to working with diverse populations.

_____

_____

_____

3. What is your current understanding of managed care systems and/or CalOptima?

_____

_____

_____

_____

4a. Please explain why you wish to serve on CalOptima's MAC.

_____

_____

_____

_____

4b. Please explain why you would be a qualified representative to serve on the MAC.

_____

_____

_____

_____

5. Do you speak any of CalOptima's threshold languages besides English (Spanish, Vietnamese, Farsi, Korean, Chinese or Arabic)?

_____

6. If selected, are you able to commit to a bimonthly MAC meeting as well as serve on at least one subcommittee? Yes ☐ No ☐

7. References (professional, community or personal):

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

City, State, ZIP: _____ City, State, ZIP: _____

Phone: _____ Phone: _____

Email: _____ Email: _____

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and resumes, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's web site, and even if not presented to the Board, will be available on request to members of the public.

_____ _____

Signature **Date**

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on the Member Advisory Committee requires that the person appointed must be a member or a family member or caregiver of a member, the member's Medi-Cal eligibility will be disclosed to the general public. The member should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT**

I understand that by signing below and applying to serve on the MAC, I am disclosing my eligibility for the Medi-Cal program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.

☐ **FAMILY MEMBER/CAREGIVER APPLICANT**

I understand that by my family member or caregiver applying to serve on the MAC, my status as a person eligible for Medi-Cal benefits is likely to become public. I authorize the incidental disclosing of my eligibility for the Medi-Cal program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.

_____

Member (Printed Name)

_____ _____

Member (Signature) **Date**

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): **Medi-Cal beneficiary status and any information member chooses to disclose in connection with his or her application for or appointment to the CalOptima Member Advisory Committee**

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow service as beneficiary representative on the CalOptima Member Advisory Committee.**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for.**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Attn: Cheryl Simmons
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that the health information used or disclosed as a result of my signing this authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure is specifically permitted or required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

Submit the completed application, your biography or résumé, and signed authorization forms to the address below or by email or secure fax:

CalOptima
505 City Parkway West
Orange, CA 92868
Attn: Cheryl Simmons
Email: csimmons@caloptima.org
Secure Fax: 714-571-2479

For questions, call 1-714-347-5785.